MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC

Requestor's Name and Address SAN ANTONIO ORTHOPAEDIC SURGERY CENTER 400 Concord Plaza, Suite 200 San Antonio, TX 78216	MDR Tracking No.: M4-04-3445-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address CITY OF SAN ANTONIO **Box 42** C/o Harris & Harris 5300 Bee Caves Rd. Bldg III, Suite 200 Austin, TX 78746	Date of Injury: Employer's Name: City of San Antonio Insurance Carrier's No.: 0027874830

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
05/13/03	05/13/03	29879-RT	$1,243.85	$0.00
05/13/03	05/13/03	29876-RT	$1,243.85	$0.00
05/13/03	05/13/03	29881-RT	$1,243.85	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's Rationale for increased reimbursement or refund as indicated on the TWCC-60 states, Not paid fair and reasonable.

PART IV: RESPONDENT'S POSITION SUMMARY

The respondent did not submit a summary position. EOB submitted with payment of $4270.05 indicated that the payment is reduced from the billed amount for treatment/service for which TWCC has not set a maximum allowable reimbursement. EOB with reconsideration indicated that the allowance given was at fair and reasonable.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is fair and reasonable reimbursement for the services provided.

After reviewing the documentation provided by both parties, it does not appear that the requestor nor respondent provided documentation that sufficiently discusses, demonstrates, and justifies their purported billed (charges) or reimbursement amount are a fair and reasonable reimbursement as required by Commission Rule 133.307.

During the rule development process for facility guidelines, the Commission had contracted with Ingenix, a professional firm specializing in actuarial and health care information services, in order to secure data and information on reimbursement ranges for these types of services. The results of this analysis resulted in a recommended range for reimbursement for workers' compensation services provided in these facilities. In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not controlling, we considered this information in order to find data related to commercial market payments for these services. This information provides a very good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

To determine the amount due for this particular dispute, staff compared the procedures in this case to the amounts that would be within the reimbursement range recommended by the Ingenix study (from 192.6% to 256.3% of Medicare for this particular year-2003). Staff considered the other information submitted by the parties and the issues related to the specific procedures performed in this dispute. After reviewing these facts and the reimbursement previously made on this claim, it

was determined that no additional reimbursement was required. The recommendation was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the recommendation, discussed the facts of the individual case, and selected the appropriate amount to be ordered in the final decision.

Based on the facts of this situation, the parties' positions, the Ingenix range for applicable procedures, and the consensus of other experienced staff members in Medical Review, we find that the requestor is **not entitled to** additional reimbursement for these services.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Ordered by:

Authorized Signature	Typed Name	08/08/05 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005 should be aware of changes to the appeals process, which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____